

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042846</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Friendship Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>826 North High Street</u> <u>Carlinville</u> <u>62626</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Macoupin</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(217) 854-9606</u> Fax # <u>(217) 854-8484</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Cathy Storr</u> <u>Principal</u> (Firm Name & Address) <u>Kellogg & Andelson Accountancy Corporation</u> <u>16162 Beach Blvd. Suite 308 Huntington Beach, CA 92647</u> (Telephone) <u>(714) 596-7713</u> Fax # <u>(714) 596-7721</u>	
IDPA ID Number: <u>330748151002</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>04/01/1997</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Cathy Storr</u> Telephone Number: <u>(714) 596-7713</u>			

Facility Name & ID Number Friendship Home# 0042846 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,934</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>49</u>	TOTALS	<u>49</u>	<u>17,934</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,495</u>	<u>6,215</u>	<u>2,488</u>	<u>16,198</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,495</u>	<u>6,215</u>	<u>2,488</u>	<u>16,198</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.32%D. How many bed-hold days during this year were paid by Public Aid?
7 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐I. On what date did you start providing long term care at this location?
Date started 03/01/93J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/97 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 2,481Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Friendship Home

0042846

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	83,294	3,918	5,363	92,575		92,575		92,575		1
2	Food Purchase		78,337		78,337		78,337		78,337		2
3	Housekeeping	34,393	5,269	8,104	47,766		47,766		47,766		3
4	Laundry	27,106	3,839	1,692	32,637		32,637	(3,990)	28,647		4
5	Heat and Other Utilities			51,772	51,772		51,772		51,772		5
6	Maintenance	1,431	1,410	5,196	8,037		8,037		8,037		6
7	Other (specify):*										7
8	TOTAL General Services	146,224	92,773	72,127	311,124		311,124	(3,990)	307,134		8
	B. Health Care and Programs										
9	Medical Director			2,700	2,700		2,700		2,700		9
10	Nursing and Medical Records	553,547	8,497	7,422	569,466		569,466		569,466		10
10a	Therapy		416	107,662	108,078		108,078	14,664	122,742		10a
11	Activities	26,518	1,919	946	29,383		29,383		29,383		11
12	Social Services	20,879		466	21,345		21,345		21,345		12
13	Nurse Aide Training										13
14	Program Transportation			33	33		33		33		14
15	Other (specify):*							7,642	7,642		15
16	TOTAL Health Care and Programs	600,944	10,832	119,229	731,005		731,005	22,306	753,311		16
	C. General Administration										
17	Administrative	94,506		102,000	196,506		196,506	(56,863)	139,643		17
18	Directors Fees										18
19	Professional Services			12,689	12,689		12,689		12,689		19
20	Dues, Fees, Subscriptions & Promotions			220	220		220	(220)			20
21	Clerical & General Office Expenses	47,620	4,756	118,422	170,798		170,798	(80,585)	90,213		21
22	Employee Benefits & Payroll Taxes			259,355	259,355		259,355		259,355		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,837	5,837		5,837		5,837		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,859	42,859		42,859		42,859		26
27	Other (specify):*										27
28	TOTAL General Administration	142,126	4,756	541,382	688,264		688,264	(137,668)	550,596		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	889,294	108,361	732,738	1,730,393		1,730,393	(119,352)	1,611,041		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Friendship Home

#0042846

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			75,117	75,117		75,117	2	75,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			16,500	16,500		16,500	295	16,795			33
34	Rent-Facility & Grounds			1,800	1,800		1,800		1,800			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			295	295		295	10,615	10,910			36
37	TOTAL Ownership			93,712	93,712		93,712	10,912	104,624			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,167	1,855	56,022		56,022		56,022			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,901	26,901		26,901		26,901			42
43	Other (specify):*		3,444		3,444		3,444		3,444			43
44	TOTAL Special Cost Centers		57,611	28,756	86,367		86,367		86,367			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	889,294	165,972	855,206	1,910,472		1,910,472	(108,440)	1,802,032			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Friendship Home

0042846

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,990)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(24,511)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,245)	21		24
25	Fund Raising, Advertising and Promotional	(2,632)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(56,195)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (104,573)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,867)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,867)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (108,440)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Friendship Home

ID# 0042846

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Dues and Subscriptions	\$ (220)	20	1
2	Bank Charges	(79)	21	2
3	Public Relations	(7,033)	21	3
4	Prior Year Expense	(2,622)	21	4
5	Prior Year Revenue	(1,384)	21	5
6	Prior Year Litigation	(25,000)	21	6
7	Depreciation reconciliation	2	30	7
8	Administrator bonus over-accrual	(20,075)	17	8
9	Real property tax reconciliation	295	33	9
10	Interest Income	(79)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(56,195)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Home

0042846

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,990)	0	0	0	0	0	0	0	0	0	0	(3,990)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,990)	0	0	0	0	0	0	0	0	0	0	(3,990)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	14,664	0	0	0	0	0	0	0	0	14,664	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	7,642	0	0	0	0	0	0	0	0	0	7,642	15
16	TOTAL Health Care and Programs	0	7,642	14,664	0	0	0	0	0	0	0	0	22,306	16
	C. General Administration													
17	Administrative	(20,075)	(36,788)	0	0	0	0	0	0	0	0	0	(56,863)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(220)	0	0	0	0	0	0	0	0	0	0	(220)	20
21	Clerical & General Office Expenses	(80,585)	0	0	0	0	0	0	0	0	0	0	(80,585)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(100,880)	(36,788)	0	0	0	0	0	0	0	0	0	(137,668)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(104,870)	(29,146)	14,664	0	0	0	0	0	0	0	0	(119,352)	29

Summary B

12/31/04

12/31/04

[illegible]

Facility Name & ID Number Friendship Home

0042846

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	15 HO Alloc Direct Care	\$	Covenant Care Inc.	100.00%	\$ 7,642	\$ 7,642 1
2	V	17 HO Alloc Indirect Care	102,002	Covenant Care Inc.	100.00%	65,214	(36,788) 2
3	V	36 HO Alloc Capital Amount		Covenant Care Inc.	100.00%	10,615	10,615 3
4	V						4
5	V						5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 102,002			\$ 83,471	\$ * (18,531) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Friendship Home

0042846

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a Physical Therapy	\$ 38,750	Select Therapy		\$ 44,166	\$ 5,416	15
16	V	10a Occupational Therapy	47,253	Select Therapy		53,858	6,605	16
17	V	10a Speech Therapy	18,909	Select Therapy		21,552	2,643	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 104,912			\$ 119,576	\$ * 14,664	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Friendship Home# 0042846Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Friendship Home # 0042846 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	n/a								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Friendship Home # 0042846 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Covenant Care Inc.
 Street Address 27071 Aliso Creek Rd.
 City / State / Zip Code Aliso Viejo, CA 92656
 Phone Number (949) 349-1200
 Fax Number (949) 349-1900

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>15</u>	<u>HO Alloc Direct Care</u>	<u>accumulated cost</u>		\$	\$		\$ 7,642	1
2	<u>17</u>	<u>HO Alloc Indirect Care</u>	<u>accumulated cost</u>					65,214	2
3	<u>36</u>	<u>HO Alloc Capital Amt</u>	<u>accumulated cost</u>					10,615	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 83,471	25

Facility Name & ID Number Friendship Home # 0042846 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Select Therapy
 Street Address 27071 Aliso Creek Rd
 City / State / Zip Code Aliso Viejo, CA 92656
 Phone Number (949) 349-1200
 Fax Number (949) 349-1900

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39 Physical Therapy				\$	\$		\$ 44,166	1
2	39 Occupational Therapy							53,858	2
3	39 Speech Therapy							21,552	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 119,576	25

Facility Name & ID Number Friendship Home # 0042846 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization Pharmacy Support Services, Inc.
 Street Address 27071 Aliso Creek Road
 City / State / Zip Code Aliso Viejo, CA 92656
 Phone Number (949) 349-1200
 Fax Number (949) 349-1900

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Banque Paribas		X	Purchase of facility		02/03/98	\$ 752,000	\$ 752,000	06/2003	various	\$ 36,703	1	
2	Less: non-care portion										(24,511)	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 752,000	\$ 752,000			\$ 12,192	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 752,000	\$ 752,000			\$ 12,192	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ n/a Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Friendship Home**# **0042846** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 16,795	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 16,795	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 16,795	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	13,975	8
	2000	14,330	9
	2001	15,029	10
	2002	16,019	11
	2003	16,795	12

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Friendship Home COUNTY Macoupin
FACILITY IDPH LICENSE NUMBER 0042846
CONTACT PERSON REGARDING THIS REPORT Cathy Storr
TELEPHONE (714) 596-7713 FAX #: (714) 596-7721

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,488
 B. General Construction Type: Exterior Frame
 Number of Stories 1

C. Does the Operating Entity?
 (X) (a) Own the Facility
 () (b) Rent from a Related Organization.
 () (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (X) (a) Own the Equipment
 () (b) Rent equipment from a Related Organization.
 (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 () YES
 (X) NO
 If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:
 3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1997	\$ 10,786	1
2					2
3	TOTALS			\$ 10,786	3

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.
 See Page 12A, Line 70 for total
 **Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations								68
69	Financial Statement Depreciation			53,545			(53,545)		69
70	TOTAL (lines 4 thru 69)		\$	\$ 53,545		\$	\$ (53,545)	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$	\$ 53,545		\$	(\$3,545)	\$	1
2	4 yards mulch 15 trees	1999	898		5	75	75		2
3	finish window installation	1999	495		5	8	8		3
4	installation of over bed lighting and order and install closet doors	1999	3,000		5	150	150		4
5	repair cable tv	1999	1,300		5	87	87		5
6	exit light kits for state requirements	1999	606		5	51	51		6
7	emergency exit lights	1999	350		5	29	29		7
8	remodeled 5 rooms, 14 closet doors installed	1999	2,800		5	280	280		8
9	slope style awning for front of building	1999	584		5	97	97		9
10	remodel of back hall 1st half	1999	7,000		5	1,167	1,167		10
11	remodel of back hall 2nd half	1999	7,238		5	1,327	1,327		11
12	slope style awning for front of building	1999	584		5	117	117		12
13	hot water heater	2000	875		5	175	175		13
14	hot water heater	2000	461		5	92	92		14
15	repair leaking pipe	2000	2,575		5	515	515		15
16	updating ventilation fan	2001	946		5	189	189		16
17	updating lighting	2001	1,086		5	217	217		17
18	completion of lighting project	2001	1,886		5	377	377		18
19	therapy addition- design development	2001	2,569		5	514	514		19
20	bedside cabinets	2001	1,009		5	202	202		20
21	bedside cabinets	2001	1,009		5	202	202		21
22	kitchen cabinet resurface	2001	4,050		5	810	810		22
23	window upgrade	2001	1,700		5	340	340		23
24	installed new outlet for steam table	2001	485		5	97	97		24
25	single/double door svstem	2001	1,683		5	337	337		25
26									26
27	heating/cooling units 3	2002	1,304		5	261	261		27
28	architectual services	2002	1,426		5	285	285		28
29	therapy gym review	2002	71,848		5	14,370	14,370		29
30	therapy gym heating/ac	2002	3,457		5	691	691		30
31	4 locks, master key	2002	382		5	102	102		31
32	2 a/c heating units	2002	960		5	256	256		32
33	Drainage & patio work	2002	10,697		5	2,139	2,139		33
34	TOTAL (lines 1 thru 33)		\$ 135,263	\$ 53,545		\$ 25,559	\$ (27,986)	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 135,263	\$ 53,545		\$ 25,559	\$ (27,986)		1
2	Replace dining room tile	2003	4,918		5	984	984		2
3	Refurb resident bathrooms	2003	8,000		5	1,600	1,600		3
4	Pt. rooms conversion	2003	1,683		5	337	337		4
5	Amana heat/cool unit	2003	532		5	106	106		5
6	Front door security system	2003	945		5	188	188		6
7									7
8	Various 1995	1995	1,075		15	72	72		8
9	Various 1998	1998	130,263		5	6,652	6,652		9
10	CCM Beginning Balance Sheet	1997	528,512		30	17,622	17,622		10
11	Replace bifold doors	2004	1,298		5	195	195		11
12	2 Compressors	2004	958		5	96	96		12
13	3 Cubicle Curtains	2004	483		5	40	40		13
14	3 Heat Cool	2004	1,415		5	94	94		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 815,345	\$ 53,545		\$ 53,545	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 125,262	\$ 21,190	\$ 21,190	\$	5	\$ 87,105	71
72	Current Year Purchases	4,424	384	384		5	384	72
73	Fully Depreciated Assets	39,761					39,761	73
74								74
75	TOTALS	\$ 169,447	\$ 21,574	\$ 21,574	\$		\$ 127,250	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1991 Ford Aerostar	1993	\$ 7,477	\$	\$	\$	5	\$ 7,477	76
77										77
78										78
79										79
80	TOTALS			\$ 7,477	\$	\$	\$		\$ 7,477	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,003,055	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,119	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,119	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 134,727	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in progress	\$ 1,084	92
93			93
94			94
95		\$ 1,084	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 47,253	\$		\$ 47,253	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			18,909			18,909	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			38,750			38,750	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				54,167		54,167	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-3					1,855		1,855	13
14	TOTAL			\$		\$ 104,912	\$ 56,022		\$ 160,934	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,600	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	50,340		3
4	Supply Inventory (priced at)	20,913		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,018		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	616,658		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 690,529	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,684		13
14	Buildings, at Historical Cost	814,447		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	171,947		16
17	Accumulated Depreciation (book methods)	(459,546)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,084		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 539,616	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,230,145	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,428	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,584		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached page 17.1	(1,295,648)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (1,219,636)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached page 17.1	752,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 752,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (467,636)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,697,781	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,230,145	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 595,972	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 595,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,399	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Contributed capital from Covenant Care Cali	983,410	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,101,809	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,697,781	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,599,751	1
2	Discounts and Allowances for all Levels	(156,236)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,443,515	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	424,230	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 424,230	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133,842	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,198	19
20	Radiology and X-Ray		20
21	Other Medical Services	16,632	21
22	Laundry	3,990	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 159,662	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 80	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached page 19.1	1,384	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,384	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,028,871	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	311,124	31
32	Health Care	731,005	32
33	General Administration	688,264	33
	B. Capital Expense		
34	Ownership	93,712	34
	C. Ancillary Expense		
35	Special Cost Centers	59,466	35
36	Provider Participation Fee	26,901	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,910,472	40
41	Income before Income Taxes (line 30 minus line 40)**	118,399	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 118,399	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Friendship Home# 0042846Report Period Beginning: 01/01/04Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,925	1,941	\$ 56,031	\$ 28.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,394	8,462	147,157	17.39	3
4	Licensed Practical Nurses	3,297	3,324	43,262	13.02	4
5	Nurse Aides & Orderlies	30,822	31,072	316,940	10.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,772	1,772	16,455	9.29	9
10	Activity Assistants	1,174	1,216	10,063	8.28	10
11	Social Service Workers	1,779	1,779	20,879	11.74	11
12	Dietician					12
13	Food Service Supervisor	1,837	1,837	17,873	9.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,260	8,457	65,420	7.74	15
16	Dishwashers					16
17	Maintenance Workers	160	160	1,431	8.94	17
18	Housekeepers	4,644	4,644	34,393	7.41	18
19	Laundry	3,531	3,539	27,106	7.66	19
20	Administrator	1,961	1,961	94,506	48.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,734	2,777	37,778	13.60	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,290	72,941	\$ 889,294 *	\$ 12.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96+mileage	\$ 3,428	1-3	35
36	Medical Director	monthly	2,700	9-3	36
37	Medical Records Consultant	16+mileage	704	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,500	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8+mileage	466	11-3	44
45	Social Service Consultant	8+mileage	466	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,264		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Kathy Abel	Administrator		\$ 94,506
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,506
B. Administrative - Other			
Description			Amount
Management Fee			\$ 102,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 102,000
C. Professional Services			
Vendor/Payee	Type		Amount
See attached invoices	Legal Services		\$ 11,969
	Physician Services		720
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 12,689
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 65,755
Unemployment Compensation Insurance			10,512
FICA Taxes			64,955
Employee Health Insurance			112,088
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401K/Other			6,045
TOTAL (agree to Schedule V, line 22, col.8)			\$ 259,355
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Dues			220
Less: Dues			(220)
Less: Public Relations Expense			(
Non-allowable advertising			(
Yellow page advertising			(
TOTAL (agree to Sch. V, line 20, col. 8)			\$
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$ 4,511
In-State Travel			948
Seminar Expense			378
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,837

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Friendship Home

STATE OF ILLINOIS

0042846

Report Period Beginning:

01/01/04

Ending:

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12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,901
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not specific to facility
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.